

CONSENT FORM

****IT IS IMPORTANT THAT THE PATIENT CHECKS HIS/HER PHYSICAL THERAPY BENEFITS WITH HIS/HER INSURANCE COMPANY, AS ALL POLICIES HAVE DIFFERENT BENEFITS AND LIMITATIONS.****

FINANCIAL RESPONSIBILITY

I realize my insurance is billed as a courtesy. I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance, unless my insurance carrier has a provider agreement with Dubuque Physical Therapy

ASSIGNMENT OF BENEFITS & CONSENT FOR TREATMENT

I consent to the plan of care and treatment by the therapist and/or his/her assistants. I hereby authorize payment of medical benefits directly to Dubuque Physical Therapy for services and/or supplies furnished. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. I further authorize the release of any medical information required to process my insurance claim. If this is a work comp claim, the authorization extends to my employer, work comp insurance company, adjuster, occupational health specialist, rehabilitation specialist, case manager or representative of my employer. I permit a copy of this authorization to be as valid as the original.

****There will be a \$20.00 charge for all returned checks.****

CANCEL/NO-SHOW POLICY

Physical Therapy Solutions considers Cancellation of Your Appointment or Not Showing for Your Appointment a serious issue, because it can make the difference between whether you will or will not attain your treatment goals.

- **Requires 2 hours advance notice**
- **Requires rescheduling an alternative appointment in order for you to receive the prescribed frequency of treatments for the week**

There may be a \$15.00 charge for no-show or cancellation of an appointment without proper notice or without rescheduling. This charge is not covered by insurance and will be billed to you personally. If there is an extenuating circumstance, please let the Medical Receptionist know. If this is a worker comp claim, the charge will be waived and your employer **will be** notified.

THIS CERTIFIES THAT I HAVE READ AND UNDERSTAND THE ABOVE AUTHORIZATIONS AND I AGREE TO THEM.

Patient Signature

Date

Staff Signature

Date

I ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW AND OFFERED A COPY OF DUBUQUE PHYSICAL THERAPY "NOTICE OF PRIVACY PRACTICES"

Patient Signature

Date

Staff Signature

Date